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Analysis of Decentralization in the Health Sector of Paraguay at the Departmental Level

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Abstract

This report provides an analysis of the decentralization process in the health sector of Paraguay at the departmental and district levels. It is based upon interviews with almost all of the departmental health secretaries, regional directors, and some municipal superintendents. The purpose of these interviews was to review progress toward decentralization at the departmental level and to analyze the challenges created by the process. The results of this assessment also provide the basis for outlining the United States Agency for International Development options for supporting decentralization in health.

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Acronyms

FIU	Florida International University
INVEC	Inventory Control System
IPS	Social Security Institute (Instituto de Previsión Social)
MSPyBS	Ministry of Public Health and Social Welfare (Ministerios de Salud Pública y Bienestar Social)
OPS/OMS	Organización Panamericana de la Salud/Organización Mundial de la Salud (Pan American Health Organization/World Health Organization
PHR	Partnerships for Health Reform Project
RHUDO/SA	Regional House and Urban Development/South America of USAID
SIF	Financial Information System of the MSPyBS (Sistema de Información Financiera)
USAID	United States Agency for International Development

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Executive Summary

The process of decentralization, instituted only recently in Paraguay, has already taken on an aspect of near inevitability. Decentralization has become the rallying point for democratically elected officials and community groups to bring about desired change. Across all sectors and geographic regions, representatives of the main political parties have engaged in debates on citizen involvement in public decision-making, while bringing the population's needs more clearly to the fore. The Ministry of Public Health and Social Welfare (Ministerio de Salud Pública y Bienestar Social [MSPyBS]) — also referred to as the Ministry of Health — has been one of the most active institutions in the country in moving toward decentralized decision-making.

Three governmental bodies are involved in the area of public health at the regional level — the departmental governments' secretariats of health, regional directorates of the Ministry of Health, and municipalities. These are the principal protagonists in the decentralization process. At the same time, the Social Security Institute (Instituto de Previsión Social [IPS]) and various health committees also play a distinct role in each region.

Based upon interviews with almost all of the departmental health secretaries, regional directorates, and some municipal superintendents, this report provides an analysis of the situation of decentralization in the health sector at the departmental and district levels. It reviews current progress toward decentralization at the departmental level and analyzes the challenges created by the process. The results of this assessment also provide the basis for specifying options for support for decentralization in health by the United States Agency for International Development Mission in Asunción.

The first section of this report presents an overview of progress made toward decentralization in health at the departmental level, including the evolution of the process. The second section presents the current status of efforts to organize departmental and district health councils. The third section provides specific data about the status of decentralization in particular departments. The final section discusses the rationale for the United States Agency for International Development support of the decentralization process and outlines potential areas for such support.

1. Introduction

In Paraguay, resources assigned to the health sector are administered by three agencies at the regional, or departmental, level:

- Departmental governments: The elected departmental governments have established health secretariats and have initiated specific activities within their respective budgetary constraints. They have also begun to organize departmental health councils to coordinate health activities in the department. Twelve departments currently have health programs and financial resources allocated to them.

- Regional directorates of the Ministry of Health: These regional offices take the lead in health planning in all regions in the country.

- Municipalities: Some municipal governments have begun to form district (local) health councils. The municipal superintendents can also include health activities in their budgets.

However, there are no formal mechanisms for coordination and reconciliation among these three actors. The coordination that does occur in some departments is entirely dependent upon the good will of those involved. In other departments, there is a complete lack of awareness and consideration of the strategic plans of other agencies.

This section begins with a review of the objectives and evolution of health sector decentralization and then assesses the process at the departmental level with respect to planning, budgeting, management of human resources, and inter-institutional relations. These areas represent critical elements of the process for transferring decision-making to those levels closest to the population.

1.1 Objectives of Decentralization

As defined in the general assessment of decentralization in the health sector, carried out in December 1995, the objectives of decentralization in the health sector are to:

- Transfer decision-making authority to the administrative levels charged with the delivering health services to the population – the district health councils. One implication of the devolution of authority is an increase in the autonomy of regional and local officials over the use of human and financial resources. This autonomy should grant health facilities the ability to manage financial resources, plan their own activities, make staffing decisions, determine drug supply needs, etc.

- Put in place health programs that which effectively meet the population's needs and demands through the active participation of communities and health providers.

- Enable the community and all stakeholder organizations to actively participate in the design of public health programs. The expectation is that when community control over resources and programs increases, programs will become more efficient and quality of care will improve.

- Raise awareness that health activities undertaken by the various actors in the decentralization process should be complementary to one another, should be based upon realistic problem diagnoses, and should be managed in a transparent way.

Comparing these objectives with the current status of decentralization activities in the departments, we can conclude that the Ministry of Health has taken the initiative in beginning the process of effective decentralization. It has established collaborative arrangements with departmental governments through monthly meetings with the secretaries of health. It has continued the deconcentration process started in 1989 by administering health programs through its regional directorates.

1.2 Evolution of the Process

In 1915, Law 112 created the National Public Assistance and the National Commission on Public Assistance and Public Welfare, centralizing public and private health care services for the first time in one special government agency. Prior to this date, health care had been under the domain of the Ministry of the Interior.

In 1936, Decree Law 2001 created the Ministry of Public Health and approved its Organic Law. Deconcentration of the central-level Ministry of Public Health began in 1940, with the creation of the first sanitary districts (Concepción, Encarnación, San Pedro, San Ignacio, Guiará). This deconcentration was only applicable to service delivery; administration of health services remained centralized. However, the sanitary regions could keep and use any contributions collected from the community; personnel could be hired provided nationally pre-established criteria were used. These provisions were formally included in the first National Health Plan (1957), which defined the roles of the regional and district health centers and health posts.

SG Resolution No. 21 of 1961 established the functions of the directors of the health regions, a promising development for decentralized management of health care services. This progress was set back by Resolution No. 2, which rescinded the ability of the regions to hire and transfer personnel. In 1980, the Sanitary Code was approved, and the Ministry of Health acquired a broader role in managing the health sector. SG Resolution No. 131 of 1982 redefined the functions of the regional directors and again permitted them to transfer personnel within their regions and to develop draft budgets. SG Resolution No. 53 of 1982 created health committees as a vehicle for community participation. These committees arose out of the need to better organize local community contributions to the health services.

The Sanitary Code defines the function of the National Health Council "...as a forum for inter-institutional and community coordination and reconciliation...to channel national, regional and local plans, programs and projects toward identified priorities in the various areas of health activity." SG Resolution No. 91 of 1994 reorganized the National Health Council. In that same year, the enactment

of Law No. 426 — the Organic Law of Departmental Government — created the departmental governments and health secretariats.

The National Health Council was created by Decree Law No. 1024/89. The regulations guiding the council's operations proposed the formation of departmental and district health councils. However, the modus operandi for these councils was not defined. In a December 20, 1995, meeting of the health secretaries, municipal superintendents, and regional directors, a Letter of Commitment was signed which gives priority to "continue supporting the cause of decentralization as a means to ensure sustained development to improve the quality of life of all residents of our departments and districts." This agreement was ratified during the same month by the House of Deputies when the latter approved the draft law creating the National Health System. This law articulates the role of the health councils as decentralized extensions of the National Health Council.

1.3 Planning

Preparation of the annual regional health plan for the departmental governments is the responsibility of the departments' secretariats of health. The secretariats are charged with collecting data and carrying out a regional diagnostic review that determines program priorities in accordance with the policies adopted by the departmental government. In some cases, this information is broadly and informally reviewed with the regional health directorate of the Ministry of Health with the goal of making the activities of these two bodies more complementary. In one department, for instance, when the target population assigned to the regional directorate exceeded its capacity, the health secretariat provided care to the group not covered.

Nevertheless, more often than not, the activities planned by the health secretariats are entirely disassociated from those of the regional health directorates and fail to use population data collected by the latter. Recent experience has raised awareness that similar activities are being carried out by both types of agencies, which has led to greater coordination of at least specific short-term activities.

At the district level, there is no system for the collection, organization, analysis, and dissemination of information with regard to public health issues. The municipal superintendents do not engage in systematic analysis of local problems or convene organized discussions on needs assessments. Meetings are held only at the instigation of the department governors, and these focus on specific topics.

The agency that takes the lead in planning within the departments is the regional directorate of the Ministry of Health. Such directorates have established systems in all regions that utilize periodic evaluations based on local diagnostic exercises at the district level. However, these plans and the results of evaluations are not currently shared in any formal way with other agencies, such as the health secretariats.

1.4 Budget

The allocation and transfer of funds to two of the three agencies responsible for administering funds for public health services in the region — the health secretariats and regional health directorates — is determined by the central government through the Ministry of Finance and the Ministry of Health, independent of where the funds originate. In both cases, authority for the review and approval of proposed budgets rests with the Congress.

Municipalities have the autonomy to decide budget issues on their own. Local budgets are approved by the municipal boards. The Ministry of the Interior is supposed to receive the necessary information to support Municipal Ordinances, through its Directorate of Municipalities. Even when such communication does not occur, however, the municipal ordinances remain valid.

Department governors, regional health directors, and municipal superintendents each have responsibility for their respective budgets, and there is no requirement for coordination among them. All budgets are subject to Organic Budget Law No. 14/68, which establishes that budgets will be prepared by the method of "budgeting by programs," which can include both "action" and "administration." Public health programs are considered action programs, but there is no requirement to include public health programs in any departmental or district budget, nor do any guidelines exist about the percentage of funds that should be allocated to public health expenditures.

District health councils are supposed to propose action programs to their executive authorities (i.e., health secretaries, governors, municipal superintendents), who in turn are to decide whether the requested amounts should be budgeted, taking into account other regional priorities.

Within the regional directorates of the Ministry of Health, the deconcentrated health service units (i.e., health centers and health posts) generate financial resources by charging minimal fees for some services. The health facilities themselves do not participate in developing the regional budget. Instead, the health facilities present programmed health activities and estimated their needs for implementing these programs, although not in economic terms. Moreover, the administrators of the service delivery facilities do not know the total regional budget available or the amount their own facility will receive, which further hampers the task of effective program planning.

Finally, the Ministry of Health lacks a cost accounting system that can provide accurate information on expenditures and revenues generated through the delivery of services. It has no monitoring system that can manage both the quality and the efficient use of resources at the health-facility level.

1.5 Human Resources

The departmental governments are new institutions still in the process of defining the content of their budgets. They do not appear to be over staffed, although it is difficult to evaluate the adequacy of their human resources without a detailed analysis of assigned tasks.

In contrast, the regional directorates and the municipal superintendents have each inherited entire staffs hired by previous administrations without, in many cases, very clearly defined and selective criteria. Generally, the municipalities have attempted to optimize their resources and, with an eye to providing evidence of the efficiency of the current superintendent, have reduced their staffs. They were able to do this due to the autonomy and authority they possess.

The situation in the regional directorates is quite different. Regional directorates personnel are part of a large group of health workers (approximately 11,000 people) distributed throughout the country whose hiring and site assignments do not always reflect community needs. Personnel administration continues to be the purview of the central-level Ministry of Health, regardless of where personnel actually work. Regional directors only have the authority to make personnel reassignments within the region itself, but they can not hire and fire. At present, most personnel assignments have been approved by the regional directors in advance, even if they didn't request such assignments and even if the Ministry of Health did not have to ask for such approval.

Employees' salaries are not always related to their capabilities and responsibilities. The regional director can make salary adjustments only in certain cases. There are some examples of support provided by the superintendencies and departmental governments to supplement salaries or provide additional personnel to health centers and posts, although these situations do not respond to any comprehensive plan or explicit institutional agreements.

Consensus exists among the three institutional actors to jointly support health promoters, the community-based volunteers who participate in public health activities, especially in health education and primary health care.

Staff at lower levels will need the capacity to take on, manage, and lead new activities under a decentralized system. The lack of administrative knowledge and experience is most evident at the municipal level.

1.6 Interinstitutional Relations

Interactions among the three institutional protagonists in the process of health decentralization have been mentioned in the previous sections. However, it is important to reiterate that no formal mechanisms or forums exist for coordination among the three different institutions, nor are there any regular channels of communication among the agencies for discussing health issues or exchanging information about their respective action programs. Any coordination that does occur is the result of the good intentions of the individuals involved. At the invitation of the Minister of Health, the health secretaries from all the departments have started to meet monthly with the ministerial cabinet to discuss the activities they are carrying out and to keep abreast of Ministry of Health's activities at the regional level.

In four departments (Caaguazú, Paraguarí, Misiones, and Alto Paraguay), the positions of regional director and health secretary are held by the same person. These individuals were already serving as regional directors when they were asked to become health secretaries. It has been considerably easier for these individuals to convene and assume leadership of the regional health councils (normally presided over by the health secretary), given their knowledge of the regional and

local health situation. Moreover, the position of regional director commands certain respect from the population as the local representative of the Minister of Health and by virtue of his "authority" to approve the delivery of services free of charge in cases of need (although fees are charged for services, the amounts are often symbolic and not based on any cost study or on users' ability to pay).

Another program that does not readily fit into the health sector decentralization scheme is the social assistance program run by the Institute of Social Security (Insituto de Previsión Social, IPS), which has service delivery units dispersed throughout the country like the Ministry of Health. This program is carried out entirely independently of other institutions. The IPS does not participate in any regional health programming or activities nor in evaluating the programs of the regional directorates. Although Ministry of Health facilities provide services to IPS affiliates, it is not reimbursed for these services.

1.7 Conclusions

The Ministry of Public Health and Social Welfare has been strengthening its administrative systems at the regional level since 1989 through staff training, the development of information systems, and the implementation of the Financial Information System (Sistema de Información Financiera, SIF). These were products of technical assistance provided by USAID within the context of the ministry's institutional strengthening program.

The computerized inventory drug management system (INVEC) currently in use at the central level is designed to operate in a network connecting all the health regions. The management training program, implemented in 1994 and 1995 and including personnel from all the regions, has prepared staff to assume responsibilities of decentralized management. Another improvement has been the establishment of operational plans aimed at strengthening regional systems, specifically by defining roles and structures of the local organizations. This component included proposed definitions of complementary roles for the regional director and the health secretary. The proposal has been presented by the Minister of Health to the health secretaries and regional directors, but has not yet received formal follow-up.

As mentioned, the good will of the Minister of Health and the regional governments notwithstanding, there is a lack of clarity about the decentralization process and an absence of formal agreements among the participating institutions. This has slowed progress toward decentralized decision-making. This is exacerbated by tension among health secretaries and regional directors, which is due in part to overlap among the responsibilities of these positions, a lack of clearly defined roles, and the political nature of these appointments. In addition, the national political situation is volatile and uncertain, with the ruling party facing internal elections. The political campaigns of the ruling party have involved, in some cases, use of public health resources as election tools.

All current municipal superintendents will leave their positions in 1996, because they cannot be reelected. This has resulted in a lack of interest to initiate activities or organize community groups, given that subsequent follow-up will not be possible. The electoral campaigns of the new candidates have attacked these deficiencies in the current municipal administrations.

Despite the caution, there is strong will and determination to continue toward decentralization, which merits direct support to all the levels involved. The final section of this report outlines a pilot project for providing such support.

2. The Current Situation in Departmental and District Health Councils

This section compares the efforts to date in each department to establish departmental and district (local) health councils, a process that was included of the Letter of Commitment signed by regional health directorates and health secretaries in December 1995. Also included is a comparison of health care resources.

2.1 Formation of Health Councils

To date, ten departments have formed departmental health councils, and seven have organized one or several district councils. These achievements demonstrate the determination of the departmental governments to move ahead with the implementation of decentralized structures in the health sector. The councils that have been organized follow the general guidelines set forth in the General Regulations of the National Health Council (Section 2).

Table 1 describes the status of the two types of councils in each department. Where the column entitled "Formed" is checked, a council has been created, has had at least one meeting, and has some written document formalizing its operations. In some cases, the councils were formed by the regional directorates (e.g., in Misiones); in others, they were formed by the departmental health secretariat or the departmental board (e.g., in Caaguazú and Concepción). The table also indicates whether a council has been recognized by resolution of the National Health Council. The column that indicates whether the councils are "Functioning" indicates whether they have carried out activities beyond their organizing meeting. The column entitled "District Councils Formed" indicates the number of local or district councils that have been formally constituted, but for which no information is available.

It should be noted that the Letter of Commitment was signed by regional directorates and health secretaries on December 20, 1995, near the start of the vacation season, when programs are effectively closing down and when the Ministry of Health and the health secretariats have completed their budgets for the coming year. This assessment was conducted during the month of February, when officials were just returning to work following their vacations and when other priorities demanded their immediate attention, such as an anti-cholera campaign. The fact that a number of councils had already become active demonstrates the local commitment to proceed with decentralization. Those councils that were not yet operational had plans to initiate activities.

Several different terms are used interchangeably to refer to these bodies, including "commissions," "councils," and "committees," among others. The regulations of the National Health Council establish the terms "departmental" and "district" councils. However, the draft law creating the National Health System – which has been approved by the House of Deputies and is under consideration by the Senate – uses the terms "regional health council" and "local health council."

Table 1.
Status of Departmental and District Health Committees, February 1996

Department	Population (1992 Census)	Number of Municipalities	Departmental Committees			District Committees Formed
			Formed	Approved by the National Health Council	Functioning	
Concepción	167,289	6	✓			
San Pedro	280,336	17	N/A	N/A	N/A	N/A
Cordillera	198,701	20	✓	✓	✓	2
Guairá	161,991	17	✓		✓	
Caaguazú	386,412	19	✓	✓	✓	1
Caazapa	129,352	9				
Itapua	377,536	29				
Misiones	89,018	10	✓	✓	✓	2
Paraguarí	208,527	17	✓	✓	✓	12
Alto Paraná	406,584	18				4
Central[1]	1,367,794	19	✓	✓	✓	3
Ñeembucú	69,770	16				
Amanbay	99,860	3	N/A	N/A	N/A	N/A
Canindeyú	103,785	7	✓	✓		
Pdte. Hayes	64,417	4	✓	✓	✓	1
Alto Paraguay	12,156	2				
Boquerón	29,060	1	✓	✓	✓	
Total	4,152,588	214	10	8	0	25

Notes: N/A = not available
✓ = yes
G = no
1. Central includes Grand Asunción

There is another kind of health committee that is organized at the neighborhood level and involves people from all levels of the community and operates according to its own clear and specific objectives. There can be up to a hundred such committees in one health region. They are recognized by the central Ministry of Health and constitute another very important means for community participation, although they are not formally mentioned in the draft National Health System Law or in the regulations of the National Health Council.

In almost all the departments, the departmental and district health councils are just starting their activities. The support provided by Florida International University (FIU) focused primarily on

creating the councils. Through two seminars, the main actors in the health sector at the departmental level — the health secretaries, regional directors, and the superintendents — committed themselves to create councils following the regulations set forth by the National Health Council. In the four-month period between the two seminars, important progress was achieved in the ten departments that participated. Although the emphasis of FIU was on creating district councils, some departments elected to begin with the organization of departmental councils. One of the biggest obstacles to actually getting the councils functioning has been the lack of understanding of the respective roles of the two types of councils and the members' lack of capacity to assume their functions.

In general, the secretary of health presides over the departmental health council, with the regional director serving as vice-president. An attempt was made by the councils to include representatives from the communities and professional groups that are involved in health care, and most councils apparently succeeded.

An important next step will be to effectively involve the local community in the work of the councils. Important geographic differences exist between districts which will affect how communities can and will participate. For example, some districts include mainly urban populations in a restricted geographic area, while others encompass a larger geographic area where the population is dispersed. Achieving representation by different community interests in broad, dispersed areas presents a challenge.

2.2 Population and Health Services

Table 2 presents information on population, government authorities, and facilities at the departmental level. Population data are from the last official census, which was carried out in 1992. The table provides information on public health services provided by the Ministry of Health, but it does not include health facilities at the departmental and district level that are operated by other agencies. For example, there was no accurate data available on facilities run by either IPS, which serves private sector workers, or private health care providers.

The table also indicates the geographic distribution of primary donor assistance. This information refers to aid provided to various public health activities. At present, none of the programs included focuses specifically on decentralization or on strengthening the representative and planning structures at the regional and local level.

In all departments, the governors and the health secretaries come from the same political party. However, in some cases, the secretaries of other departmental agencies (e.g., education, public works) come from different political parties.

Table 2.
Ministry of Health Services by Department, as of February 1996

Department	Population	Number of MOH Physicians	Number of MOH Hospitals	Number of MOH Health Centers	Number of MOH Health Posts	Donors Supporting Health Programs
Concepción	167,289	27	1	5	26	WB
San Pedro	280,336	20	1	10	42	WB
Cordillera	198,701	63	1	18	18	IDB
Guaira	161,991	33	1	8	28	IDB
Caaguazú	386,412	47	1	11	50	IDB
Caazapa	129,352	12	1	8	29	IDB, JICCA
Itapua	377,536	63	1	13	62	SPAN, GTZ
Misiones	89,018	25	1	10	17	SPAN, GTZ
Paraguari	208,527	37	2	15	23	IDB
Alto Parana	406,584	70	1	7	38	WB
Central	1,367,794	130	2	18	23	IDB
Ñeembucú	69,770	11	1	4	26	SPAN, GTZ
Amanbay	99,860	28	1	3	14	WB
Canindeyú	103,785	8	1	3	18	WB
Pdte. Hayes	64,417	24	1	4	19	SPAN, GTZ
Alto Paraguay	12,156	6	1	2	11	WB
Bogueron	29,060	2	1	3	12	SPAN, GTZ

Notes: IDB = InterAmerican Development Bank
GTZ = Dutch Corporation
JICCA= Japanese aid agency
SPAN = Spanish Corporation
WB = World Bank

2.3 Budget Allocations for Health by Department

A key condition for the success of decentralization is the transfer of control over budgetary resources for public health. Decentralized management of budgets also offers the possibility of greater transparency over public expenditures by local representatives and the community. Financial data from district-specific expenditures are easier for community participants to understand than data aggregated for the national level. The accounting for the use of funds is also easier when those providing oversight are familiar with both the programs being carried out and local conditions within which these programs are being implemented.

The current budgetary process within the departments, municipalities, and health facilities is neither transparent nor decentralized. However, despite the tight control exercised over budget allocations at the central level, regional directorates have been given authority to develop their own budgets and are working with their respective departmental deputies to gain support for their proposals. The implementation of the SIF at the central level has also been a positive step in this process, because it provides current information to the health regions about the level of budget disbursement at any given time.

Table 3 outlines the distribution of funds for health action programs by department for 1996.

Table 3.
Distribution of Budgets for Health Expenditures by Department, in Guaranies, 1996

Departments (or Sanitary Regions)	Total Departmental Budget	Departmental Budget for Health	Percentage of Total Budget for Health	Budget of Ministry of Health
Concepción	3,564,283,598	47,165,270	2.77	5,928,259,800
San Pedro	3,250,942,600	74,169,500	3.62	5,493,944,530
Cordillera	3,975,119,176	125,750,000	6.06	6,374,445,500
Guaira	2,641,643,450	133,001,310	5.03	5,181,130,000
Caaguazú	5,369,037,096	34,537,500	1.00	6,335,406,600
Caazapa	3,125,001,481	19,500,000	1.01	4,003,043,600
Itapua	4,757,866,372	N/A	N/A	7,637,050,100
Misiones	3,171,313,100	107,433,100	6.12	4,305,323,400
Paraguari	3,351,131,500	77,650,000	419.00	5,161,154,600
Alto Parana	6,443,936,000	310,388,000	7.20	8,108,333,600
Central[1]	8,884,096,365	806,754,000	13.00	17,897,557,800
Ñeembucú	3,165,000,000	158,000,000	9.19	3,924,046,450
Amanbay	3,463,844,335	N/A	N/A	3,988,782,900
Canindeyú[2]	3,584,849,741	N/A	N/A	3,258,274,600
Pdte. Hayes	3,094,273,224	28,600,000	1.37	4,140,288,350
Alto Paraguay	3,141,943,225	N/A	N/A	2,685,308,300
Boquerón	3,621,882,400	N/A	N/A	2,543,880,400
Total	68,606,163,663	1,922,948,680	N/A	96,966,230,530

Notes: N/A = not available
1. Central includes Gran Asunción
2. Canindeyú has no budget line for health.

The total departmental budget represents the amount approved by the Congress for each department. These funds are administered by the respective departmental governments through their accounts with the Ministry of Finance.

The departmental budget for health is the amount of the departmental budget destined for health activities for which plans have been reviewed by the Ministry of Health and Congress. Spending on health is a decision made by individual departmental governments and is not required by law. There is no uniformity in the allocation of health budgets across departments. The table indicates what percentage of the total budget is spent on health, which includes funds administered by the departmental governments that are assigned to specific health programs.

The table also indicates the amount assigned from the general budget of the Ministry of Health to each health region. These amounts are administered by the regional directorates, which deposit the funds with the Ministry of Finance and subsequently request use of funds against the deposits. (Even revenues collected by the service delivery units themselves are sent to the Ministry of Finance.)

These two regional budgets — from the departmental governments and from the regional directorates — remain entirely separate, from preparation to final expenditure and reporting. Similarly, the budget of the Social Security Institute for each department is separate and is not shared with other health-related institutions.

2.4 Conclusions

The differences among the departments in the progress taken toward decentralization appear to be related to the fact that some governors place more importance on the health sector or exert more influence over their departmental boards than others. As a result, some departments are moving ahead to create departmental and district health councils and have allocated resources from their annual budgets to health. Other departments are initiating activities in collaboration with the regional health directorates.

There is no mandate or timetable to carry out these activities from the Ministry of Health, the National Health Council, or Congress. Nevertheless, there is growing enthusiasm at the local level to move forward with decentralization, and departments are beginning to share experiences with each other, which may help continue and quicken the process.

3. The Situation by Department

3.1 Department of Concepción

- Population: 170,000
- Health Structure: six districts; experiences logistical difficulties due to lack of roads in the department.
- Councils: The departmental health council has been created by order of the departmental board, which defined their members, objectives, and functions. The stated intent to create district health councils has not been fulfilled. The department is interested in undertaking a pilot decentralization program in one district where the administrators of health resources could test coordination of planning and implementation of activities.
- Planning: The departmental government has included health activities in its 1996 annual plan.
- Budget: The departmental government has assigned a budget for health activities, as indicated in *Table 3*.
- Relations between the secretariat and the regional directorate: Activities are coordinated. Inter-institutional agreements have even been developed indicating the feasibility to share resources across institutions. The Model for Integrated Activities in Health and Development at the departmental level which was developed in 1994 is designed to enable policy makers and managers to make timely decisions based on data and to implement departmental plans.

3.2 Department of Cordillera

- Population: 198,000
- Health Structure: 20 districts
- Councils: The departmental health council has been formed, has ongoing meetings, and is organized according to the guidelines established by law. The council has been approved and recognized by the departmental government and the Ministry of Health. Two district councils have been formed, in Tobatí and Piribebuy. Piribebuy, a city of 20,000 people, has started a health decentralization and municipalization project in which management of the health center has been transferred to the district council and the local municipal government. It is premature to evaluation the results of this new venture, which does, however, demonstrate the willingness of ministry and departmental government officials.

- Planning: The health secretariat and the departmental council have developed action plans that are being implemented with the participation of community-based volunteer promoters. The regional directorate, which supports the plans undertaken by the secretariat, is currently focussed on reducing maternal and infant mortality in the department. The Mobile Hospital Project initiated by the departmental council will collaborate in health promotion and care by reaching under served populations not covered by Ministry of Health services. There are plans to make Piribebuy and Tobatí districts pilot areas for the municipalization of health services.

- Budget: The departmental government has a line item for health and for the two district councils that have been formed.

- Relations between the secretariat and the regional directorate: It is said in the department that the Ministry of Health reaches only 5 percent of the population, leaving 95 percent to be covered by the secretariat. The first instances of coordination with the regional director of the IPS have begun, obtaining his participation on the departmental council.

3.3 Department of Guairá

- Population: 161,200

- Health Structure: 17 districts

- Councils: The departmental health council has been organized and has applied for recognition by the National Health Council. The secretariat of health has approved the formation of a district council in the departmental capital (Villarrica).

- Planning: The health secretariat is in the process of developing its 1996 health plan. There are no provisions yet to include a line item for the departmental health council in the 1996 health budget.

- Budget: The departmental government has a line item assigned to health.

- Relations between the secretariat and the regional directorate: Departmental health activities in the department are discussed on an ongoing basis with the regional director, who serves as the vice-president of the departmental council.

3.4 Department of Caaguazú

- Population: 386,000

- Health Structure: 19 districts

- Councils: The departmental health council has been organized, with the secretary of health as president. The superintendent of the departmental capital (Coronel Oviedo) serves as the vice-president, since the regional director and the secretary are the same person. (Normally, the regional director serves as vice-president of the departmental health

council.) The district health council of San José de los Arroyos has been established and recognized by the secretariat of health.

- Planning: There is no health plan, but the regional directorate and the secretariat of health carry out joint activities. Neighborhood health committees have been formed spontaneously in the outlying communities and have been authorized directly by the secretary of health. Some 50 health committees have been formed; 29 of these administer active Social Pharmacies.

- Budget: The departmental government has a line item assigned to health in 1996 which is designed to support deworming and vaccination campaigns and other public health programs.

- Relations between the secretariat and the regional directorate: In this department, the health secretary and the regional director are the same person. This individual considers the post of health secretary to be hierarchically superior to that of regional director and feels that the latter post should be eliminated and all activities centralized in the secretariat of health.

3.5 Department of Itapua

- Population: 378,000

- Health Structure: 29 districts (This department has a high population density.)

- Councils: The departmental health council has not been formed. Officials have decided to wait for specific regulations and definition of roles by the National Health Council before forming councils. They were uninformed about the general regulations that describe the organization and operation of the departmental and local councils. There are three existing health committees, similar to district councils in terms of their recognition by the department, in the municipalities of Trinidad, Natalio, and San Rafael. Plans are to organize a district council in Coronel Bogado.

- Planning: The secretariat of health is developing a work plan which will eventually be shared with the regional directorate.

- Budget: The departmental government has a budget assigned to the health sector.

- Relations between the secretariat and the regional directorate: Due to the absence of the secretary of health (for training), major joint activities have not been undertaken, though there appears to be a willingness to coordinate work.

3.6 Department of Misiones

- Population: 89,000

- Health Structure: 10 districts

- Councils: The departmental council has been formed. Two district health councils (in Yabebyry and Ayolas) have been organized and recognized.

- Planning: Plans are developed by the regional directorate since the person who serves as secretary of health previously served as regional director.

- Budget: The secretariat of health has its own budget. The two municipalities with district councils are supporting health activities with local resources.

- Relations between the secretariat and the regional directorate: In this department, both posts are held by the same person. Both institutions are supporting a project of rural agents and volunteer promoters.

3.7 Department of Paraguarí

- Population: 210,000

- Health Structure: 17 districts

- Councils: The departmental council has been formed and approved by the National Health Council. Twelve district councils have been created in the past two months with the approval of the secretariat of health. No information was available about the operation of these councils.

- Planning: Action plans have been prepared. The superintendents support the decentralization process.

- Budget: The departmental government has a budget assigned to the health sector which is complemented by that of the regional directorate. With these two budgetary sources, the department is in a condition to allocate funds to support activities in the health centers and posts, pay salaries, contract professionals, maintain equipment, maintain and repair physical infrastructure, and procure medical equipment.

- Relations between the secretariat and the regional directorate: Both positions are held by the same person. Social welfare activities are being carried out in collaboration with the secretariat of education. The secretary of health actively participates in the meetings and activities of the departmental board.

3.8 Department of Alto Paraná

- Population: 407,000

- Health Structure: 18 districts

- Councils: A departmental council has not been formed. The department expects to organize one when conditions are more propitious, but for now greater priority is given to work with the communities than to convening the official representatives in the

department. Four district councils have been formed in the main urban centers of the department, Ciudad del Este, Hernandarias, Franco, and Minga Guazú.

- Planning: The regional directorate has very detailed activity plans. There is no integrated departmental health plan.

- Budget: The 1996 departmental budget has line items for renovations of health centers and posts, purchase of drugs, repair of equipment, and payment of physicians. The regional directorate does not know the content of the departmental budget.

- Relations between the secretariat and the regional directorate: The health secretariat lends support to the regional directorate, in some cases, providing vehicles for the vaccination campaigns and other planned activities. However, no budgetary information-sharing takes place.

3.9 Central Department

- Population: 1,367,794

- Health Structure: includes Greater Asunción and 19 districts

- Councils: The departmental council has been formed and approved by the National Health Council, and district councils have been organized in San Lorenzo, Ypacaraí, and Capiatá. The district council in San Lorenzo was the first in the country.

- Planning: The health secretariat is working on the basis of specific projects, such as the high school health course for fourth- , fifth- , and sixth-year students, which is designed to motivate young people to participate in health promotion and prevention. The regional directorate is now authorized to procure its own drugs directly. Health centers and health posts communicate their needs to the regional directorate, who then makes the purchases accordingly.

- Budget: The departmental government has a health budget which has already been used to improve the operation of health centers and posts. An example is the creation of a department of neonatology in the San Lorenzo district, purchasing equipment, and covering the salary of the neonatologist.

- Relations between the secretariat and the regional directorate: Since their respective objectives and functions have not been delineated, the activities of the regional directorate and health secretariat often overlap and parallel policies have been developed. The recent change in regional director is expected to improve relations.

3.10 Department of Ñeembucú

- Population: 70,000

- Health Structure: 16 districts, 4 health centers, and 28 health posts

- Councils: No councils have been formed.
- Planning: The departmental government has a budget for health.

3.11 Department of Canindeyú

- Population: 104,000
- Health Structure: 7 districts
- Councils: The departmental health council has been formed.
- Planning: The departmental government does not have a budget for health.

3.12 Department of Presidente Hayes

- Population: 65,000
- Health Structure: Includes 32 indigenous colonies with 17,500 inhabitants but no health posts.
- Councils: The departmental council has been formed and approved by the National Health Council. The district council of Benjamín Aceval has been formed. There has been no decision on forming a district council in Villa Hayes (the departmental capital).
- Planning: The health secretary indicated that help is needed to prepare a departmental health plan with the active participation of all actors in the health sector.
- Budget: The departmental government has funds allocated to health and is currently planning the construction with departmental government funds of a hospital for the indigenous population.
- Relations between the secretariat and the regional directorate: They coordinate their work and have joint programs for medical care, drugs, and vaccines to reach the least accessible populations. The secretariat provides transportation and pays physicians. There has not been any coordination yet with the municipal superintendent.

3.13 Department of Alto Paraguay

- Population: 12,000
- Health Structure: 2 districts, 2 health centers, and no regional hospital
- Councils: Have not been formed.
- Planning: Develops plans with the regional directorate, for example, to train health promoters.

- Budget: The departmental government does not have a budget for health.
- Relations between the secretariat and the regional directorate: Both positions are held by the same person.

3.14 Department of Boquerón

- Population: 29,000
- Health Structure: 60 percent of the population is indigenous.
- Councils: The departmental council has been formed and has records of its meetings.
- Planning: Has developed a health plan for 1996.
- Budget: No budget for health assigned by the departmental government.

4. Possible Program Support from USAID

Within the strategic planning process of USAID/Asunción, support for decentralization is one of the proposed courses of action to achieve the strategic objective of strengthening democracy in the country. At the time of this report, this strategic objective had not yet been finalized, but it is likely that USAID/Asunción's program will focus on increasing the government's sensitivity and accountability to the population by improving community participation in government activities.

Decentralization is considered one of the greatest transformations of public administration in Paraguay since elected government was introduced in 1989. Even though decentralization is still in its initial phases, the departments and municipalities have taken the challenge of representing the population and undertaking development programs to meet its needs seriously. The sectors of greatest local interest are education, public works, and health. Several departments have included development programs in these sectors within their budgets.

The health sector has taken the greatest strides toward decentralization, including by deconcentrating management to the regional directorates and building close collaboration among the Ministry of Health and the health secretariats of the departmental governments. This assessment attests to the dedication and determination with which departmental and municipal authorities support decentralization within the health sector. The programming of financial resources for health within several departmental and municipal budgets has also begun.

With respect to community representation, the councils that have been formed or planned offer the population access for the first time to formalized decision-making structures for health activities. The health sector represents one of the areas of greatest concern to the population. Progress in the creation of district health councils will make it possible for communities to make their voices heard and to help improve the planning and use of health resources.

Conditions within the health sector appear favorable to advancing the process of decentralization, offering the population real access to participation in decision-making about the use of public funds and strengthening the responsiveness and accountability of the government in using public funds.

Strengthening community participation in the management of health programs at the local level cannot occur in a vacuum and should form an integral part of decentralization on a broader scale. To ensure the success of community participation in the local health councils, it is necessary to provide support at all levels — local, regional, and central — and to build relations among the different levels. At the same time, it is important to assist communities in utilizing the opportunities available to participate in decision-making and directing their energy toward programs that improve their health or help improve the quality of health services provided. Below is an outline of a broad program of support.

4.1 Develop a Common Vision about Decentralization

Decentralization is a long-term process that will affect all sectors of government. The current lack of clarity and consensus regarding the decentralization model being followed in Paraguay, and the absence of a recognized legal framework, produces anxiety and uncertainty among those involved. Given the interest in and intensive debate about decentralization, an essential first step is to develop consensus around a common vision for the decentralization process. It is premature to expect consensus about the model of decentralization in the government as a whole, but it is possible to develop a common vision for a pilot decentralization project in the health sector. Such a project, implemented in selected departments and districts, would provide results and lessons about decentralization that could be used elsewhere in the country as well as in other sectors.

One component of this vision should be a clear definition of the roles and responsibilities of the health secretaries and regional directors. While the legal framework for decentralization as a whole is being developed, an open dialogue among all the key actors could produce agreement as to current ground rules to be used in the pilot health project. Such an ongoing dialogue would also lead to a deeper understanding of what decentralization means at the regional and local levels, what repercussions and responsibilities decentralization brings to communities, and what resources are being offered by the departmental and district health councils.

Creating a common project vision should be an ongoing process that includes participation by everyone involved. Building a concept of the process is fundamental. On one hand, it allows ongoing refinement and revision of people's understanding and implementation of the decentralization pilot model over time. On the other hand, it helps design the pilot project itself. The inclusion, from the outset, of all actors and beneficiaries in designing the pilot project is one way to ensure broad-based political support for the activities. A common vision for the pilot decentralization project can be built through a strategic planning process at both the central level and within each region where pilot activities will take place.

4.2 Selecting Pilot Departments

The following criteria may be considered for the selection of the pilot departments:

- The department has already formed a departmental council.
- Political will exists at the department level to work in the health sector.
- The department already has a budget for health activities.
- There is an adequate educational level among the municipal superintendents.
- The positions of health secretary and regional director held by a single person.
- The department is geographically accessible.

4.3 Components of the Pilot Project

Following is a brief summary of some of the components that would need to be included in a pilot project.

4.3.1 Strengthening Institutional Capacity

One of the essential components of USAID support to the decentralization process should be strengthening the institutional capacity and personnel of the institutions participating in the process. As noted above, it is crucial that this strengthening occur at all levels of the system and should address the relationships among the central and departmental levels and the departmental and local levels. Support for the district health councils in the pilot departments will be a key component of the project.

The type of support should be determined with the direct participation of council members, but should include approaches for assessing the health status of communities, identifying priorities for health programs, managing quality improvement programs, and working in teams of community representatives. This would include working with neighborhood committees, non-governmental organizations, and other private groups. Each council should have broad representation from community groups.

4.3.2 Defining Roles and Responsibilities at the Central Level

The project should include a component of support to the central level of the Ministry of Health to help it define and assume its normative and supervisory role vis-à-vis the regions.

4.3.3 Transfer the Management of Human Resources

Parallel to the need to develop district health councils is a need for systems for human resource management that allow decision-making power to be transferred to the departmental and health center levels.

4.3.4 Management of Financial Resources

Apart from clarifying the roles of the various councils and the means for collaboration between the different levels, an important obstacle to successful operation of the councils is the lack of control over budgets. This is particularly clear at the health-facility level, where administrators do not know their own budgets and do not control expenditures for personnel, supplies, or drugs. Given that the revenues collected by the facilities are not controlled by facility administrators but are transferred to the Ministry of Finance for subsequent reallocation, there is little incentive for enhanced revenue collection or efficient resource use. Furthermore, the health secretaries do not know how much is budgeted for their departments by the Ministry of Health. Whatever cooperation now exists between

the health secretaries and the regional directors is the result of the good will of the individuals occupying these positions and does not translate into better control by the departmental governments of health activities in their departments.

There are several possible models for transferring authority, and these should be discussed with the various actors during the project planning process. This discussion ought to cover the transfer of central funds to the departments and the municipalities and the coordination of budgets and expenditures within departments. Examples include the allocation of resources to be managed at the department level or by regional hospitals and/or health centers. Another important component to consider is a program for cost recovery.

4.4 Sustainability

Strengthening democracy will not be achieved unless technical assistance programs lead to more effective participation in government by ordinary citizens. By focusing support on district health councils, USAID can expect to contribute to the development of a new form of participatory government. Without technical support, the success of the councils will depend solely on the existing management capacity at the departmental and local levels. By strengthening the councils and assisting them in assuming their responsibilities and becoming involved in all stages of health activities, it is assumed that these groups can develop into permanent organizations which will give communities the opportunity to take responsibility for the health of their populations.

This process will be sustainable to the extent that agreements on the model and implementation of decentralization are developed with broad participation of all actors involved, at the central, regional, and local levels. Long-term success will also depend on the success of decentralization in improving the health of the communities in which the program is being implemented. An important factor in this success will be the extent to which agreements reached have been effectively implemented, particularly concerning the transfer of funds, the devolution of authority to regional officials, and local capacity-building.

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